Vicarious Liability: Relocating Responsibility For The Quality Of Medical Care

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I. INTRODUCTION AND SUMMARY

Managed health care has recently generated a great deal of distrust, even anger, in the public mind. To be sure, much of this public reaction is based on anecdotal evidence and one-dimensional thinking.¹ But many unbiased experts observing managed care today are themselves unhappy with the health care industry's performance. While these observers find little justification for the current political backlash against managed care, they are also disappointed that today's health plans have not made a more positive difference.² Indeed, informed observers commonly regret that the new arrangements for the financing and delivery of care have done so little to get physicians to adopt truly efficient practices, achieving not only cost reductions but also substantial improvements in health status and patient outcomes—that is, in the quality of care. Although managed care has not demonstrably harmed the overall quality of health care in the United States, it has done little to improve it.³

In the view of many, therefore, the managed care revolution that began in earnest in the early 1980s remains a half-baked affair today. Simply giving managed care more “baking time” does not seem to be the answer, however, because

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¹ Most criticisms of managed care overstate the case against it by failing to account for the substantial cost savings managed care has achieved, and by using the unlimited entitlements that consumers came to take for granted in the era of unconstrained fee-for-service medicine as a benchmark. See, e.g., GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* 13-15, 22 (1996) (one-sided journalistic attack on health maintenance organizations (HMOs), alleging defects in HMO systems with occasional adverse consequences).

² See WALTER A. ZELMAN & ROBERT A. BERENSON, *THE MANAGED CARE BLUES AND HOW TO CURE THEM* 102-18 (1998); Robert A. Berenson, *Beyond Competition*, *HEALTH AFF.*, Mar.-Apr. 1997, at 171, 171-72; Randall R. Bovbjerg & Robert H. Miller, *Managed Care and Medical Injury: Let's Not Throw the Baby Out with the Backlash*, 24 *J. HEALTH POL., POL'Y & L.* 1145 (1999); Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, *HEALTH AFF.*, May-June 1997, at 134, 143-44.

³ See R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Care*, 76 *MILBANK Q.* 649, 673 (1998) (finding “little evidence of any consistent difference in clinical quality between [fee-for-service] and [HMOs]”); Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, *HEALTH AFF.*, Sept.-Oct. 1997, at 7, 13-14, 20-22.

something about the recipe itself is apparently leaving many consumers and most knowledgeable critics unsatisfied. Moreover, the health care industry may be unable to produce more savory versions of managed care at reasonable cost if the recipe continues to be dictated by law and regulation⁴ or if government imposes new liability risks on plans that take aggressive measures to control costs.⁵ There are, of course, other things that policymakers might do to inspire health plans to create more appetizing products. For example, many experts hope that new methods of measuring quality and reporting provider performance will soon make quality differences more salient and enable consumers and their agents to demand improvements. It is not clear, however, that information alone, or any other strategy under active consideration, can create enough new pressures on health plans or providers to trigger radical managerial reforms of the kind that may be necessary to raise the quality of care appreciably. Public policy has not yet hit upon an approach that will cause health plans and their subcontractors to concern themselves with quality in health care as much as they do currently, and controversially, concerned about its cost.

This Article suggests a legal reform that would more clearly establish the ultimate responsibility of health plans for the quality of the health services their enrollees receive. Specifically, it recommends legislation establishing as a so-called "default rule" (that is, a legal rule that operates in the absence of a different contractual arrangement) the principle that a health plan is vicariously, and exclusively, liable for medical malpractice and other torts committed by health care providers whom it procures to treat its enrollees. Put simply, the argument is that health plans, and not individual doctors, should be legally accountable in the first instance for the quality of care delivered to patients just as they are currently accountable to employers and consumers for the cost of care. Not only is it logical to have responsibility for cost and quality initially assigned to the same entity, but factual circumstances relevant under the common law of agency also point in this direction. Thus, today's health plans routinely select providers or provider organizations to treat their enrollees with low cost as the dominant criterion. Even

⁴ Even though managed care plans already take more of their cues from legal prescriptions than from prospective customers seeking good value for their money, the political outcry against them suggests that the public still deems them insufficiently accountable for the quality and quantity of care that patients receive. The recent flare-up of populist zeal is rapidly adding new regulatory prescriptions to the already lengthy list of rules with which plans must comply. See Alice A. Noble & Troyen A. Brennan, *The Stages of Managed Care Regulation: Developing Better Rules*, 24 J. HEALTH POL., POL'Y & L. 1275 (1999); Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUSTON L. REV. 1319, 1359-74 (1996). See generally Tracy E. Miller, *Managed Care Regulation: In the Laboratory of the States*, 278 JAMA 1102 (1997) (examining significant state regulation of managed care between 1995 and 1996). On regulatory proposals at the federal level, see generally JOHN S. HOFF, *THE PATIENTS' BILL OF RIGHTS: A PRESCRIPTION FOR MASSIVE FEDERAL HEALTH REGULATION* (Heritage Found. Backgrounder No. 1350, Feb. 29, 2000) (partisan description and critique of pending legislation); Frank Bruni, *Curbs on Managed Care Still Divide Parties*, N.Y. TIMES, Mar. 17, 1999, at A18; Donald W. Moran, *Federal Regulation of Managed Care: An Impulse in Search of a Theory?*, HEALTH AFF., Nov.-Dec. 1997, at 7, 19-20.

⁵ The current political firestorm is threatening in particular to consume certain federal statutory protections that health plans currently enjoy against certain kinds of state regulation and against personal injury lawsuits alleging mistakes by plans in enforcing coverage limits in their contracts with subscribers. See generally HOFF, *supra* note 4; Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1996) (discussing the stifling effects of the Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.) on state regulation of managed care).

more ominously, they compensate these subcontractors in ways that may induce them to neglect or undertreat individual patients. For these reasons and also because health plans are in an excellent position to control provider performance directly (as necessary) or to induce downstream actors with whom they do business to make quality improvements, a common law court or a legislature could easily conclude that health plans should bear presumptive responsibility whenever their providers breach a legal duty to an enrollee.

The recommended "default rule" would leave health plans free, however, to shift the new liability risk to downstream subcontractors. As a result, the liability burden in most cases would finally come to rest on a provider entity to which the health plan has also shifted substantial financial risk for the provision of health services.⁶ Thus, the proposed legal reform would not be inconsistent with current trends under which health plans are offering consumers a wider choice of providers and increasingly distancing themselves from the actual provision of care, confining themselves to such functions as negotiating and administering contracts with employers, building and maintaining provider networks, and bearing whatever financial risks they do not download to subcontractors.⁷ Even though health plans may be finding it unpopular to limit consumer choices, or inefficient to integrate vertically and involve themselves directly in the delivery of care, quality should be on the table in negotiations between plans and providers. Such negotiations currently proceed on the traditional assumption that tort liability concerns only individual providers and their individual patients. The legal change envisioned in this Article would make the extent and allocation of liability risks a concern of health plans and thus a new subject for bargaining between plans and potential subcontractors. As a result, whatever incentives tort law provides to deter bad practice and to maintain and improve the quality of health care would operate universally on entities that are well positioned and well equipped to take action to enhance quality. Quality considerations would thus be incorporated in many decisions that are currently driven by cost concerns alone. One cannot be certain exactly how health plans or provider organizations on which liability risks devolve by contract would respond to such a change in their legal environment. There are reasons to believe, however, that tort law's deterrence signals are more likely to induce quality improvements when they are directed at health care organizations rather than individual practitioners.

Although "vicarious liability" has been advocated from time to time, usually under the label "enterprise liability,"⁸ it is not currently on any prominent reform

⁶ As explained later, the proposed legislation would bar a health plan or a subcontractor from restoring the traditional, arguably dysfunctional pattern, by shifting the liability risk all the way back down to individual physicians or small physician groups. See *infra* Part IV. Room would be left, however, for consumers to elect pure indemnity coverage with unlimited choice of provider or a plan with a point-of-service option—in which cases a patient injured by provider negligence would look for compensation only to the provider he selected.

⁷ See generally James C. Robinson, *The Future of Managed Care Organization*, HEALTH AFF., Mar.–Apr. 1999, at 7 (overview of trends in health care organizations).

⁸ See William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, LAW & CONTEMP. PROBS., Spring 1997, at 159, 162–66 (describing how the term "enterprise liability" was used by the Clinton administration's health reform task force in floating a version of vicarious liability in 1993). For other endorsements of "enterprise liability," see William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 1–2 (1994) (joining a "chorus of voices that proposes to refocus liability for medical malpractice on the organizations that will increasingly bear practical responsibility for providing health care services"); David M. Studdert & Troyen A. Brennan, *Deterrence in a Divided World: Emerging Problems for Malpractice Law in an Era of Managed Care*, 15 BEHAV. SCI. & L. 21, 48

agenda. Instead, the debate over the liability of managed care plans has centered only on whether to authorize lawsuits against plans for their *own* alleged negligence or breaches of contract, not on making plans or their subcontractors liable when physicians fail to meet their professional obligations to patients.⁹ Many health care experts are concerned, however, that the political movement to intensify legal controls over managed care is distracting attention from a more general quality problem in American health care and that the health care industry is neglecting large opportunities to improve the quality of care through better management.¹⁰ In combination with efforts to provide more quality information to the public, legislation that places the legal onus for medical accidents initially on health plans could prove to be an important step in harnessing the plans' bargaining power in the effort to improve quality and to achieve overall efficiency in health care spending. These considerations all strongly point toward making vicarious liability a central feature of public policy toward managed care.

Part II of this Article briefly discusses the state of U.S. health care today, first emphasizing how thoroughly managed care has disappointed expectations and then noting an important separate development, the raising of new concerns about the entire health care system's shortcomings with respect to the quality of care. Part III stresses the need both for radical organizational reform to improve quality and for a new paradigm of responsibility for clinical care, suggesting that vicarious liability, implemented as proposed, might provide the needed impetus for change. Part IV then explains the proposal to make exclusive vicarious liability the default rule for organized health plans and argues the policy case for adopting it. Part V attempts to put to rest important and legitimate concerns about the effects of the proposed strategy on the professionalism of physicians. Part VI briefly examines the current law on vicarious liability, noting why legislation is necessary even though courts are increasingly exposing health plans to such liability. Finally, Part VII argues for adopting the proposal despite the serious objection that malpractice law has not proved to be a very reliable source of incentives to improve the quality of medical care.

II. THE HALF-BAKED REVOLUTION

Although today's health plans and their subcontractors have begun an important revolution, their actual accomplishments to date fall short of the goals envisioned for managed care when it first came on the scene in the 1970s and early 1980s. At that time, policy experts expected competing health plans to organize providers into discrete, competing groups, each undertaking distinctive collaborative efforts to improve the quality of care while also controlling costs. However, the vision of health plans actually organizing and directly overseeing providers has not been

(1997) (concluding that enterprise liability, though "no panacea for achieving sharp deterrence in the malpractice sphere, . . . [is] capable of correcting some aspects of the incompatibility between malpractice law and new organizational models"). See generally Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 587-647 (1997) (developing themes elaborated in this article). Reasons for preferring the term "vicarious liability" are discussed *infra* note 53.

⁹ See, e.g., HOFF, *supra* note 4; Mariner, *supra* note 5, at 1986.

¹⁰ For an article with a compelling title that makes this point, see generally Robert H. Brook, *Managed Care Is Not the Problem, Quality Is*, 278 JAMA 1612 (1997).

realized.¹¹ The reasons for this outcome are several. A health plan that is large enough to realize economies of scale in performing its core functions would face serious diseconomies of scale if it attempted to manage health care itself.¹² In addition, there are questions about the propriety of entrusting managerial authority to corporate entities that lack legal responsibility for the quality of care. In any event, today's health plans act almost exclusively as general contractors at least once removed from providers and the actual delivery of care.

In addition to distancing themselves from the provision of health services, today's health plans have rarely made substantial efforts to induce their subcontractors to improve providers' overall performance by coordinating their efforts and rationalizing their clinical methods. Some plans have responded to demands by sophisticated purchasers by steering patients to so-called "centers of excellence" for certain highly specialized services and imposing some reporting and quality-related requirements on their subcontractors.¹³ However, these measures are only a nod in the direction of quality improvement. In reality, most plans are not rigorously selective in their choice of subcontractors. Rather than screening for demonstrated competencies and demanding the organizational changes necessary for superior performance, most plans offer eligibility to provide covered services to virtually any provider-subcontractor willing to accept the plan's financial terms.¹⁴ At the health plan level, therefore, managed care today means little more than subcontracting and capitation, techniques that allow health plans to exercise their purchasing power over providers and to transfer to them much of the financial risk in meeting enrollees' health care needs.¹⁵ Although they actively negotiate the prices they will pay, health plans delegate responsibility for most other matters to a wide variety of subcontractors and exercise very little influence over those subcontractors' performance.¹⁶

Most of today's health plans do, however, engage in some explicit rationing of health care financing. So-called "predetermination of benefits," undertaken by designated utilization managers who determine whether certain services that physicians propose to prescribe fall within the plan's coverage,¹⁷ allows plans to

¹¹ See Robert A. Berenson, *Beyond Competition*, HEALTH AFF., Mar.-Apr. 1997, at 171, 171 (noting that "the logic of managed competition suggests that within each health care market, networks with different and distinct organizational characteristics and internal cultures will form and compete" but that "health care markets have not evolved that way").

¹² See Robinson, *supra* note 7, at 19 (explaining "the economics of vertical disintegration" and observing, "[t]he administrative, information, and clinical competencies required for an organization that actually delivers health care are quite distinct from those of an organization that develops, markets, and monitors contractual networks.").

¹³ See ZELMAN & BERENSON, *supra* note 2, at 88.

¹⁴ See *id.* at 69-72.

¹⁵ Thus, most of today's health plans fill roles similar to those filled by indemnity insurers in the fee-for-service area, acting essentially as third-party financiers of care that is decided upon, for the most part, by largely autonomous subcontractors and the physicians they select.

[T]he most recent trends suggest that . . . managed care plans may wind up watering down their products to such a degree that the potential for real coordination and for cost and quality control may be lost. Today much of managed care—with expanding networks of physicians and groups, easier access to specialists, and in some situations, less intrusive utilization review—is beginning to look and act ominously like the old fee-for-service system, only with lower provider reimbursement rates.

Id. at 12.

¹⁶ See *id.* at 65.

¹⁷ See *id.* at 73.

husband the funds contributed by their subscribers without directly interfering in doctor-patient relationships. However, because this practice is cumbersome, controversial and legally risky, it is giving way to more extensive capitation arrangements. As subcontractors assume more responsibility for delivering promised services, cost control is often achieved through *sub rosa*, or secret, rationing by clinicians whose choices are influenced by financial incentives to economize.¹⁸ Given both the relative transparency of predetermination of benefits and the distinction between rationing financing and rationing actual care, one would think that predetermination is preferable as a cost-control strategy over undisclosed rationing at the bedside.¹⁹ Even so, health plans are entrusting greater responsibility for the quantity as well as the quality of care to a variety of independent contractors and the physicians they engage.²⁰

To be sure, even though health plans are not actively managing care themselves, their subcontractors may be appropriately managing it in consumers' interest. Yet these subcontractors are generally selected because of their low costs, not because of their demonstrated skill in managing care and improving its quality. They are, in any event, a very mixed bag, including such entities as unorganized "preferred providers" and more or less organized independent practice associations (IPAs), physician networks, management services organizations, provider-sponsored organizations, physician-hospital organizations, and other so-called integrated delivery systems.²¹ Judging from recent bankruptcies and other signs of financial distress, many of these entities are incapable of managing costs effectively. It is even more doubtful that many of them are committed to, or effectively engaged in, raising quality standards and improving patient outcomes.

Many of the subcontracting entities to which health plans are delegating responsibility for providing appropriate care to their enrollees were created by providers primarily to bargain with health plans on their behalf, not to facilitate the efficient management of care.²² All of them, moreover, operate in a climate strongly influenced by the medical profession's preferred paradigm of medical care, under which physician autonomy is sacrosanct and financially interested middlemen lack legitimacy in dealing with matters traditionally deemed to fall within the realm of the

¹⁸ See *id.* at 81-82.

¹⁹ In theory, physician decisions are cabined by the legal duty to adhere to professional standards, creating a presumed accountability that allows health plans to disclaim responsibility for rationing decisions that physicians make. But the tactic of shifting rationing responsibility to physicians may soon not be so readily available, depending on the outcome of a case currently pending in the U.S. Supreme Court. See *Hedrick v. Pegram*, 145 F.3d 362 (7th Cir. 1998), *reh'g en banc denied*, 170 F.3d 683 (7th Cir. 1999) (four judges dissenting), *cert. granted*, 120 S.Ct. 10 (1999) (raising the question of whether *sub rosa* rationing by physicians under financial incentives to limit care provided is subject to challenge as a fiduciary breach under ERISA).

²⁰ To be sure, health plans still engage in some explicit rationing of "experimental" treatments. It would seem that they do so, however, only because new technologies are by definition not yet governed by professional standards. See CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM*, 190-200 (1995) (arguing that health plans defer excessively to professional standards rather than developing their own contractual ones and, following this logic, that they should cease distinguishing between experimental and other procedures).

²¹ See BARRY R. FURROW ET AL., *HEALTH LAW* § 5-49 (West Hornbook Series 1995) (differentiating between various forms of integrated delivery systems).

²² See U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy in Health Care* 61 (Statement 8: Physician Network Joint Ventures, August 1996) (describing and applying antitrust law to physician efforts to engage in collective bargaining with health plans).

doctor-patient relationship. In keeping with this paradigm's tenet that physicians are accountable only to patients for the quality of care, virtually all health plans today include in their contracts with subscribers a disclaimer of responsibility for the care that their subcontractors provide.²³ By telling enrollees, in effect, "Don't sue us, sue your doctor," health plans have cut themselves out of the picture at precisely the point where the quality of the care actually received by patients comes into view.

At this stage in the managed care revolution, therefore, corporate health plans have assumed extensive responsibility for the cost of care without accepting more than nominal responsibility for its quality.²⁴ Only a minute's reflection should suggest that this situation is unlikely to be satisfactory as a matter of public policy. Certainly, there is no evidence that the overall quality of care has suffered under managed care. But if health care were being *appropriately* managed in the age of managed care, we would discover not only that managed care has not harmed the quality of care, but that it has significantly improved it. Managed care aside, the health care industry as a whole is being criticized today by knowledgeable physicians and health services researchers for its generally disappointing performance with respect to quality. A recent report by the Institute of Medicine, citing studies in Utah, Colorado and New York, estimated that a very large number of deaths per year result from medical errors in hospitals.²⁵ The Harvard Medical Practice Study, for example, conducted in New York hospitals in the early 1980s before managed care became a significant factor, discovered iatrogenic injuries in nearly four percent of hospitalizations and found that approximately one percent of hospitalized patients suffered an injury caused by legally actionable negligence.²⁶ The study extrapolated those findings to estimate that as many as 150,000 preventable deaths may occur in the nation's hospitals each year.²⁷ Other experts have detected widespread overuse, underuse and misuse of medical technologies that lead to adverse effects on patients' health.²⁸ The public has a right to expect managed care to improve a situation that

²³ See HAVIGHURST, *supra* note 20, at 118-22; see also *Petrovitch v. Share Health Plan, Inc.*, 719 N.E.2d 756, 762-63 (Ill. 1999) (quoting provisions in HMO literature). Aetna-U.S. Healthcare HMOs include the following clause in their subscriber contracts: "Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Members for all Medical Services which are rendered by Participating Physicians." See Complaint, *O'Neil v. Aetna Inc.*, 2:99CV284 (S.D. Miss. Hattiesburg Div. complaint filed Oct. 7, 1999). Similarly, Aetna's member handbook instructs enrollees to "understand that participating doctors and other health care providers who care for you are not employees of the HMO and that the HMO does not control them." *Id.* These provisions, obviously inserted by the HMOs for the purpose of avoiding vicarious liability, have been challenged in recent class-action litigation as a misrepresentation of the actual relationship between Aetna HMOs and their physicians, implying more independence than actually exists. This charge calls attention to how plans are trying to have it both ways, avoiding legal responsibility while seeking to influence physician decisions.

²⁴ Cf. *Maio v. Aetna, Inc.*, No. CIV. A. 99-1969, 1999 WL 800315 (E.D. Pa. Sept. 29, 1999) (defendant health plans successfully defended themselves in class action for fraud by alleging that the "statements concerning th[eir] commitment to quality health care are 'mere puffery'").

²⁵ See COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 33-34 (Linda T. Kohn et al. eds., 1999).

²⁶ See 1 HARVARD MED. PRACTICE STUDY, *PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK* 3, 6-1, 6-9, 11-1 (1990); see also David M. Studdert, et al., *Costs of Medical Injuries in Utah and Colorado*, 36 INQUIRY 255 (1999) (analyzing iatrogenic injuries in Utah and Colorado hospitals).

²⁷ See PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* 55 (1993).

²⁸ See Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 MILBANK Q. 565, 570-78 (1998); see also Marc A. Schuster et al., *How Good is the Quality of Health Care in the*

has so much room for improvement.

In addition to deploring the lack of quality improvement, experts have also noted the primitive character and questionable effectiveness of the tools traditionally employed to ensure quality in American medicine. Traditional "quality assurance," they have observed, concentrates principally on identifying individuals to hold personally accountable for particular mishaps and on disciplining a small subset of providers, the proverbial "bad apples," deemed to be responsible for system failures.²⁹ By contrast, other industries have achieved striking quality improvements by focusing on prospective improvement of entire systems by better monitoring, data analysis, employing rigorous scientific methods to identify quality problems and to evaluate possible solutions, and designing systems to accommodate inevitable human error.³⁰ Some health care experts have advocated importing these quality-enhancing techniques, including methods known as "continuous quality improvement" (CQI) or "total quality management" (TQM), into health care.³¹ Although a number of health care organizations have achieved notable quality improvements using these innovative methods, those successes have occurred principally in hospitals and reflect only the professionalism and competitiveness of the organizations' managers, not the influence of managed care. The changes wrought by modern health plans in American health care, while certainly revolutionary, do not yet include better management techniques for ensuring the quality of care.³²

III. TURNING UP THE HEAT

Perceiving that the managed care revolution is still half-baked, politicians are actively looking for ways to turn up the heat on health plans. Although command-and-control regulation is the usual legislative instrument of choice, the challenge to policymakers is to create a climate in which the totality of the legal prescriptions and incentives at work, both market and non-market, push plans to do whatever is necessary to ensure that patients receive the appropriate quantity and quality of care. In health care, the market alone cannot provide appropriate incentives to maintain quality because consumers cannot, in most cases, reliably assess the value of the

United States?, 76 MILBANK Q. 517, 517-63 (1998).

²⁹ See TROYEN A. BRENNAN & DONALD M. BERWICK, NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE 297-333 (1996) (describing techniques of "repair"—the identification of quality failures after the fact, followed by aggressive action to prevent their recurrence—and "culling"—the forceful removal of defective elements from a system).

³⁰ See Lucian L. Leape, *Error in Medicine*, 23 JAMA 1851, 1852 (1994) (discussing the aviation industry); Chassin, *supra* note 28, at 567-70 (discussing industrial processes).

³¹ See Donald M. Berwick, *Continuous Quality Improvement as an Ideal in Health Care*, 320 NEW ENG. J. MED. 53, 53-56 (1989); Chassin, *supra* note 28, at 578-87. See generally BRENNAN & BERWICK, *supra* note 29, at 297-333; IMPROVING CLINICAL PRACTICE: TOTAL QUALITY MANAGEMENT AND THE PHYSICIAN (David Blumenthal & Ann C. Scheck eds., 1995) (collection of works analyzing various continuous quality improvement and total quality management applications in health care); MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE 244-67 (1997) (constructive journalistic appraisal of weaknesses in the implementation of medical knowledge, expressing optimism concerning prospects for improvement); Leape, *supra* note 30, at 1857 (classic article advocating systematic attention to preventing errors in treatment).

³² "Unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability. . . . Most third party payment systems provide little incentive for a health care organization to improve safety, nor do they recognize and reward safety or quality." COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, *supra* note 25, at 3.

services they receive. The policy problem, therefore, is to narrow the extent to which consumer ignorance allows providers to give less than optimal care without adverse consequences either to themselves or to the health plan sponsoring the care.³³ Although efforts to give the public better information on provider and health plan performance are certainly worthwhile, it is unrealistic to think that consumers will ever be informed enough to preclude some sellers from foisting poor quality on some of them.³⁴ Regulation can also provide only sub-optimal protection, because it imposes only minimum standards, which by definition do not push plans to be all that they could be.

Theorists of managed care contemplate that providers are unlikely to take the measures needed to improve the quality of care or to achieve appropriate balances between quality and cost containment unless they are integrated in efficient organizations that compete with each other for the rewards that come from giving the best value for the money consumers are willing to spend. As noted above, however, well-integrated health care teams are not common, and today's health plans have only rarely served as vehicles for major organizational or managerial change. Moreover, organizing efficient provider entities to replace established patterns is extremely difficult in a culture of medical care that glorifies physician autonomy and opposes middleman interference. Therefore, it will not be sufficient simply to cajole health plans and their various subcontractors to address quality problems as a public or professional responsibility or to rely on new quality information to strengthen market forces enough to stimulate needed change. The relevant actors must have clear market and non-market inducements to pursue quality and efficiency that are strong enough to force health plans and their subcontractors to think "outside the box." They must be made willing to reshape delivery systems in fundamental ways, to adopt radically new management methods, and to redefine the role of physicians in decision making. Whatever political heat they generate, the incentives deployed must put some key actors' feet to the fire.

Students of health care management have observed that, while some health care organizations have employed CQI, TQM, and similar error-reduction methods to good effect, few of them have permanently built such methods into their infrastructures.³⁵ David Blumenthal, a pioneer in the CQI/TQM field, has expressed

³³ See Dudley et al., *supra* note 3, at 655–56 (observing that "when quality is hard to measure, there are many ways to increase return on equity by lowering quality," and that "[i]n situations where consumers or payors are more sensitive to price than quality—[perhaps] because they cannot measure quality . . . —it may also be possible to increase return on equity without providing high quality").

³⁴ See, e.g., Mark R. Chassin et al., *Benefits and Hazards of Reporting Medical Outcomes Publicly*, 334 NEW ENG. J. MED. 394, 395 (1996) (finding that patients did not avoid hospitals or physicians based on New York State's publication of mortality rates for coronary bypass surgery). Despite the fact that health plans did not respond to New York State's publication of mortality rates, (perhaps because of purchasers' disinterest in quality, lower prices charged by poorer hospitals, or the fact that, unlike many other adverse outcomes, a heart patient's death involves few additional costs to the plan and indeed may actually save it money), the New York disclosures did apparently lead to improved outcomes, perhaps because institutions were concerned about their reputations. See Edward L. Hannan et al., *Improving the Outcomes of Coronary Artery Bypass Surgery in New York State*, 271 JAMA 761, 761, 763–65 (1995).

³⁵ See Stephen M. Shortell et al., *Assessing the Impact of Continuous Quality Improvement on Clinical Practice: What Will It Take to Accelerate Progress*, 76 MILBANK Q. 593, 609 (1998) ("Although there are 'pockets of improvement,' no evidence has yet emerged of an organization-wide impact on quality."); David Blumenthal & Charles M. Kilo, *A Report Card on Continuous Quality Improvement*, 76 MILBANK Q. 625, 635 (1998) ("There simply are no organization-wide success stories out there. . . ."); see also Mark R. Chassin, *Improving the Quality of Health Care*, 335 NEW

concern that health care organizations might never undertake revolutionary changes such as those required by the CQI/TQM approach if they do not face a threat to their survival.³⁶ Observing that it took a "brush with death" to revolutionize American auto manufacturing in response to competition from quality-oriented foreign automobile manufacturers, Blumenthal has looked in vain for a source of comparable pressure on health care providers and institutions.³⁷

Vicarious liability would be a potentially important new source of incentives that might inspire health plans and their subcontractors (hereafter referred to collectively as MCOs) to reinvent themselves in the interest of quality improvement.³⁸ In law-and-economics theory, tort liability is valued specifically because it can compensate for severe difficulties that consumers may have in recognizing and evaluating quality limitations in the goods and services they buy.³⁹ In health care markets, the difficulty of making quality judgments is particularly great, because disappointing outcomes are not uncommon or necessarily attributable to poor care and because services are generally purchased on a prepaid basis before the consumer's specific needs are known. Even more ominously, fear of adverse selection gives health plans and providers a disincentive to strive for better quality, because success in building a reputation for providing superior care is likely to attract patients who are disproportionately sicker and more demanding yet do not add commensurately to gross revenue. The incentives that vicarious liability would introduce into MCOs' decision making would not only internalize the costs of avoidable medical accidents but also offset the market's perverse discouragement of quality improvement.

Vicarious liability would induce health plans to act as sophisticated agents for consumers in selecting providers, thus overcoming the information deficit that consumers face in purchasing medical care and consequently enhancing quality. Although health plans could perform a very valuable service to chronically under-informed consumers by searching the market for skilled providers and monitoring the quality of their performance, the legal system currently discourages such quality-assurance efforts. Thus, many states have enacted "any willing provider" laws that protect individual providers from plans that seek to exclude them from treating plan enrollees.⁴⁰ In addition, health plans naturally fear that taking any responsibility for the quality of care provided would increase their exposure to vicarious liability⁴¹ or to liability for so-called "corporate negligence" in selecting providers.⁴² By presuming that all plans have such responsibility, vicarious liability would cause them to be significantly more particular with respect to the skills and performance of the physicians they designate to provide covered services.

ENG. J. MED. 1060, 1060-62 (1996) (observing physician distrust of quality-assurance efforts).

³⁶ See Blumenthal & Kilo, *supra* note 35, at 635.

³⁷ See *id.* at 637-38.

³⁸ See Kenneth Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 417-18 (1994).

³⁹ See PATRICIA DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 5 (1985).

⁴⁰ See generally Jill A. Marsteller et al., *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL., POL'Y & L. 1133 (1997) (analyzing state "any willing provider" and "freedom of choice" laws).

⁴¹ See *infra* note 67.

⁴² See, e.g., *Elsesser v. Hospital of Philadelphia College*, 802 F. Supp. 1286, 1291 (E.D. Pa. 1992) (recognizing HMO duty triggered by representations of selectivity).

Certainly, making health plans or their subcontractors legally responsible for providers' torts would not alone provide the near-death experience that may be necessary to make quality "Job One" in American health care. Liability risks do get organizations' attention, however. Moreover, shifting the legal risk in this case would greatly contribute to a needed paradigm shift in the health care sector, away from a purely professional model of medical care to one that contemplates a high degree of organizational responsibility. Thus, even if relocating legal responsibility for the quality of care is not a *sufficient* condition for getting health plans and their subcontractors to focus serious organizational attention on improving quality, it is almost certainly a *necessary* one. There is at least some basis for hoping that, together with increased disclosure of performance statistics and increasing market demand for optimal quality, vicarious liability would help ignite the next phase of the managed care revolution.

IV. WHY VICARIOUS LIABILITY?

To clarify the concept of vicarious liability as advocated in this Article, the Appendix sets forth statutory language that Congress or a state legislature⁴³ might enact to establish it.⁴⁴ This language is intended to make vicarious liability the default rule for all health care financing plans.⁴⁵ Under the model statute, the liability burden for provider torts would fall on the plan entity in the first instance, but could be shifted downstream to other provider entities by explicit contractual provisions instructing enrollees where to look for compensation in the event of a compensable injury. One possibility under the proposed statute is that a hospital could, by contract, be made legally responsible for physician malpractice as well as for other negligence occurring therein.⁴⁶

As the statute is drafted, however, a health plan or subcontractor could not shift the liability risk all the way back down to individual practitioners or to small practitioner groups if those individuals or groups were preselected by the plan or one of its subcontractors. Thus, liability would fall on individual physicians only if the patient chose to have a traditional doctor-patient relationship through the purchase of pure indemnity coverage or went "out of plan" for treatment—using a point-of-service option, for example. The chief reason for allowing liability risks to be shifted

⁴³ It is notable that ERISA would probably not preclude a state legislative initiative or a state court ruling adopting vicarious liability as a matter of common law. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 351–61 (3d Cir. 1995) (allowing a vicarious liability malpractice claim against an HMO for a physician's tort to proceed in state court; holding that ordinary state efforts to police quality were not preempted by ERISA); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 153–55 (10th Cir. 1995); *Hinterlong v. Baldwin*, 720 N.E.2d 315 (Ill. App. 1999).

⁴⁴ The proposed statute is offered for discussion purposes, and any questions about its drafting should not distract attention from the larger issues.

⁴⁵ Although the term "health plan" is not defined, it would be defined broadly to include even indemnity insurers and self-insured employers. Because vicarious liability would apply only as a default rule, however, such entities could shift the liability burden routinely to more appropriate risk bearers.

⁴⁶ Thus, a health plan could, if it seemed efficient, arrange for roughly the allocation of responsibility prominently advocated by Kenneth Abraham and Paul Weiler. See Abraham & Weiler, *supra* note 38, at 415–20. This allocation would minimize opportunities for plaintiffs to sue both a hospital for its own (or its employees') alleged negligence and the plan (or its subcontractor) for a physician's alleged malpractice. See *id.* at 406. One object of the default rule would be to authorize contractual arrangements that save the litigation costs and double exposure associated with lawsuits targeting multiple defendants.

only to group practices or other provider-controlled entities above a certain size is that only such larger entities are capable of managing the risk better than the health plan itself. One goal in adopting vicarious liability would be to give MCOs an incentive to select subcontractors that are in a position to improve the quality of care rather than merely providing covered services in conventional, unmanaged ways.

A key premise of the proposal to establish vicarious liability is that assigning liability risks to individual physicians, as the current system does, does not promote good industry performance. There are many reasons to doubt that malpractice law as we know it motivates physicians to strive for optimal quality. Liability insurance insulates physician tortfeasors against financial losses in individual cases, and it is generally not priced so that future premiums reflect the physician's actual claims experience. In addition, individual physicians may be slow to modify their performance to ward off claims because they are in psychological denial about their own shortcomings or because they have personal limitations that prevent them from seeing how they could improve their performance. Alternatively, they may simply perceive malpractice claims as random, unavoidable events—as to some extent they are. It may be the case that the *in terrorem* effects of malpractice suits on individual practitioners deter enough bad practice to justify preserving the current malpractice system despite its high transaction costs.⁴⁷ However, no one except self-interested trial lawyers argue that the current tort law system is an effective instrument for optimizing quality.

In his classic work exploring the economics of tort liability, *The Costs of Accidents*, Guido Calabresi suggests that, when choosing among candidates to bear a certain type of liability risk, the law should seek to identify “the cheapest cost avoider,” the party best positioned to see the whole picture, including the relevant trade-offs and to take appropriate actions to prevent injuries themselves or induce other parties to take them.⁴⁸ The new intermediaries that have appeared in the health care market since the advent of managed care fit the profile of cheapest cost avoiders very well, making them the appropriate bearers of liability risks. For example, MCOs facing liability would either self-insure or face experience-rated premiums for liability insurance. In addition, because they would be exposed to many more potential claims than a single practitioner faces, they would have less reason to view malpractice claims as random events and more reason to regard their frequency and severity as being within their control. Moreover, insofar as a liability-bearing MCO

⁴⁷ See DANZON, *supra* note 39, at 226 (“rough calculation suggests that if the number of negligent injuries is, generously, 20% lower than it otherwise would be because of the incentives for care created by the malpractice system, the system is worth retaining, despite its costs”); Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL., POL'Y & L. 463, 473–79 (1992) (finding, through interviews, that physicians made changes in their practices as a result of malpractice litigation pressure; also finding that physicians greatly exaggerate the risk of suit, leading to protective behavior); Gary T. Schwartz, *Reality in Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 444 (1994) (estimating that the current malpractice system probably justifies its cost). The deterrent effect of the National Practitioner Data Bank (to which malpractice judgments and settlements against individual physicians must be reported and which must be consulted by entities having future dealings with those physicians) need not be lost in a system based on vicarious liability. See 42 U.S.C.A. § 1320a-7e (1999) (establishing the National Practitioner Data Bank).

⁴⁸ See GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 135–73 (1970) (recommending a general deterrence approach to accident liability, including assigning liability in such a way as to create incentives to ensure appropriate attention to quality and to target parties who, given transaction costs, are generally in the best position directly or indirectly to control quality and to influence outcomes).

also bears the costs of treatment, it could expect quality improvements to save money not only by reducing claims but also by eliminating the need to treat iatrogenic injuries.⁴⁹ Finally, MCOs facing both treatment costs and liability risks may be more rational than individual physicians with respect to so-called "defensive medicine," defined as costly and arguably inappropriate services that some physicians allegedly prescribe in the belief that it will lessen their risk of being sued.⁵⁰

The expectation that vicarious liability would induce MCOs to undertake needed quality improvements is supported by limited evidence that hospitals are more responsive than individual physicians to deterrence signals sent by the tort system.⁵¹ However, a possible concern may be that shifting responsibility to an upstream entity would relieve the *in terrorem* pressure of the tort system on individual physicians, with possible harmful effects. Nevertheless, liability would still turn on whether the physician had breached a professional duty to the patient. The process of litigating that issue may not be made any more pleasant for the physician by imposing the financial burden of any judgment on an MCO employing his services rather than on his malpractice insurer. Moreover, entities subject to vicarious liability could monitor physicians' performance to detect and correct dangerous practices whether or not they had attracted the notice of plaintiffs' lawyers.⁵² Physicians would therefore

⁴⁹ See generally Chassin, *supra* note 35 (discussing the fact that cost-concerned managed care organizations (MCOs) were seeking to improve quality of care delivered by their providers). While MCOs surely bear many of these costs already, vicarious liability would give them not only new reasons to concern themselves with quality but also new legitimacy in demanding that providers make quality improvements.

⁵⁰ Under old forms of financing, physicians could, at no cost to themselves, seek to avoid the unpleasantness of future malpractice suits by taking special precautions, whether appropriate or inappropriate. Capitation arrangements, however, may make the provider bear the cost of such precautions while not affecting the weak, largely non-financial incentives to take them. Once again, one sees the need to keep quality (that is, patient outcomes) centrally in view in an increasingly cost-sensitive environment.

⁵¹ See Troyen A. Brennan, *The Role of Regulation in Quality Improvement*, 76 MILBANK Q. 709, 721 (1998) (reporting "a deterrent effect in analyses of hospitals but not of individual physicians, which suggests that hospitals recognized the deterrence signal but that physicians did not."). Hospital risk management and quality-assurance programs were installed following the 1970s malpractice crisis and appear to be more than mere attempts to assuage criticism or to comply minimally with statutory requirements. For further elaboration on such programs, see generally JAMES E. ORLIKOFF & AUDRONE M. VANAGUNAS, *AMERICAN HOSP. ASS'N, MALPRACTICE PREVENTION AND LIABILITY CONTROL FOR HOSPITALS* (2d ed. 1988); GLENN T. TROYER & STEVEN L. SALMAN, *HANDBOOK OF HEALTH CARE RISK MANAGEMENT* (1986); WILLIAM O. ROBERTSON, *MEDICAL MALPRACTICE: A PREVENTIVE APPROACH* (1985) (a physician's report on risk management in Washington State). But see Laura L. Morlock & Faye E. Malitz, *Do Hospital Risk Management Programs Make A Difference?*, LAW & CONTEMP. PROBS., Spring 1991, at 1, 20-22 (finding little effect of risk management, other than certain educational activities, on malpractice claims experience in 40 hospitals).

⁵² See Mark F. Grady, *Why Are People Negligent? Technology, Nondurable Precautions, and the Medical Malpractice Explosion*, 82 NW. U.L. REV. 293, 310-11 (1988) (observing that much negligence theory is concerned with inducing "durable precautions," such as the installation of better systems and methods, and not with punishing mere human errors). A key to better prevention is systematic reporting of untoward events, which providers currently resist out of fear of triggering lawsuits or other adverse consequences in a system prone to assigning blame whenever an injury occurs. Although vicarious liability would not entirely overcome physicians' fears in this regard, MCOs are in a good position to induce disclosure, by penalizing non-disclosure, taking an understanding attitude toward human error, employing sensitive information constructively in collaborative efforts with physicians to prevent recurrence, and ensuring that the information is protected from discovery in litigation by statutory privileges. See generally COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, *supra* note 25, at 74-113.

be subject to greater pressure to avoid such practices than they are today.

V. WOULD PROFESSIONALISM SUFFER?

Some physicians and other observers will inevitably oppose vicarious liability because they fear or object in principle to the strengthened corporate oversight of professional practice that such a change in the industry's legal environment might trigger. However, any increased corporate oversight accompanying vicarious liability would reflect new quality, not cost, concerns, and would therefore almost certainly be more benign than its opponents fear. Moreover, an MCO would be vicariously liable only when a physician had breached a recognized professional obligation.⁵³ MCOs required to bear the risk of such liability would therefore have good reasons to foster professionalism and not to jeopardize patient welfare by overriding sound professional judgment. Indeed, MCOs facing legal accountability for quality failings would probably find it a wise management strategy to rely upon the professionalism of their physicians, demanding and encouraging their collaborative efforts to improve patient outcomes and cure deficiencies that invite future lawsuits.

MCOs operating under a legal regime featuring vicarious liability would evaluate physician performance more rationally and realistically than the legal system currently evaluates it in malpractice suits featuring the testimony of partisan experts. A reassuring analogy to the oversight that MCOs would seek to implement is found in the staff privileges system in hospitals. Beginning in the 1960s, as hospitals became increasingly responsible for physician torts in emergency rooms and other hospital settings, hospital governing boards and administrators gained stronger hands in dealing with their physicians and began to make more demands on their medical staffs. Even as hospitals came under cost pressures from purchasers, their demands on doctors were largely legitimate ones. Moreover, those demands were almost always made within the confines of a model of hospital governance that respected professionalism while also emphasizing accountability to the institution.⁵⁴ In better hospitals at least, medical staffs have conscientiously undertaken to maintain and improve the quality of care. Although vicarious liability could bring about some power shifts in managed care settings, physicians have no strong reason to fear that their professionalism would be undermined or usurped.

Vicarious liability would be the default rule not only in cases of physician negligence and malpractice but also when a physician fails to perform other legally

⁵³ Indeed, the author's reason for preferring the term "vicarious liability" over "enterprise liability"—both terms are familiar to lawyers—is that the former term better conveys that the plan's liability is derivative under agency principles, not direct. The distinction between the two kinds of plan liability, vicarious and direct, is important to preserve in this context precisely because it underscores that it is the physician, not the plan, who actually provides care and has the primary legal duty to the patient—that is, that medical care remains a professional, not a corporate, undertaking even under managed care. "Enterprise liability," on the other hand, not only obliterates this crucial nuance, but it is also often understood to involve some departure from the fault principle and, in health care contexts, to include—or even to stand exclusively for—plans' liability for negligence or bad faith in administering coverage and managing utilization.

⁵⁴ See JOINT COMM. ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS MS.1 (1997) (stating hospital accreditation requirement: "One or more organized, self-governing medical staffs have overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore [sic] to the governing body."); see also Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1077–92 (reviewing the role of physicians in hospital governance).

recognized professional duties. For example, an MCO would be potentially responsible if one of its physicians fails to inform a patient of an alternative treatment or diagnostic measure that might have provided a significant medical benefit. Even if the MCO, rightly or wrongly, would not have paid for the alternative treatment, the patient is entitled to know of the option so that he or she can choose whether to pay for it out of pocket, get another opinion, or challenge the MCO's adverse coverage decision. Holding health plans or their subcontractors liable for breaches of this duty should make these intermediaries more inclined to encourage full disclosure by physicians to patients than they do currently.

Vicarious liability would also subject a health plan or its subcontractor to a potential claim whenever a physician it selects fails to present a patient's case for coverage competently and with reasonable vigor within whatever predetermination process the plan maintains. Some have hypothesized that physicians have a general professional, and even a legal duty to serve as an "advocate" for patients against health plans in all circumstances.⁵⁵ Such a duty would be too sweeping, however, both because physicians owe duties to the health plans they work for and because most health plans' decisions are not, in fact, illegitimate, necessitating physician resistance.⁵⁶ Indeed, a health plan can be said to have a right, and even a duty, to see that the funds that premium payers have pooled to meet health needs are not wasted or misspent in individual cases. Nevertheless, a treating physician should be legally responsible for giving plan decision makers complete information and a careful interpretation of the clinical situation in order to improve the chances that the patient will get the care that he or she is contractually entitled to. Holding the health plan or a subcontractor vicariously liable when these duties are breached should make the plan properly respectful of responsible efforts by physicians to represent their patients' interests vis-à-vis the plan.

The two legal duties of physicians mentioned here as additional subjects for vicarious liability are implicit in the professional-patient relationship and have probably always existed in legal theory.⁵⁷ With the advent of managed care, however, these duties have gained great practical importance as protections against both plan and physician abuses of patient interests. The medical profession has expressed the concern that so-called "gag clauses" and other health plan policies have discouraged doctors from informing patients of their options and from assisting them in dealing with the plan.⁵⁸ An equally serious concern, however, may be that some

⁵⁵ See, e.g., George J. Annas, *A National Bill of Patients' Rights*, 338 NEW ENG. J. MED. 695, 698-99 (1998) (listing "the right to an advocate" as one of five "rights" of managed care enrollees); Jerome P. Kassirer, *Managing Care—Should We Adopt a New Ethic?*, 339 NEW ENG. J. MED. 397, 397-98 (1998).

⁵⁶ See William M. Sage, *Physicians as Advocates*, 35 HOUSTON L. REV. 1529, 1571-74 (1999).

⁵⁷ But see Joan Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261 (1999) (questioning whether law clearly requires disclosure of alternative treatments and advocating clarification).

⁵⁸ See *Issues and Standards for Managed Care: Hearings on H.R. 2976 Before the Subcomm. on Health and Env't of the House Comm. on Commerce*, 104th Cong. 66, 66 (1996) (statement of the American Medical Association, presented by Robert E. McAfee) (stating that gag clauses "undermine a physician's ability to provide his or her patients with the best possible care"). "Gag clauses" are implicit or explicit components of physician-MCO contracts that "prohibit physicians from discussing certain topics with their patients, such as how the physician is compensated or what uncovered treatment options the physician believes are potentially beneficial." Julia A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED. 433, 441 (1996).

doctors allow themselves to be coopted by plans to such an extent that they fail either to inform their patients of their medical options or to assist them in getting the services they are entitled to under their plans' contracts. Exasperated by what they may feel are unreasonable plan policies, some physicians may simply wash their hands of responsibility in the face of plan-initiated cost controls. Yet these controls cannot work well unless physicians act professionally in representing their patients' legitimate interests. Not only should courts and plaintiffs' lawyers ensure that physicians are observing their professional obligations in these respects, but MCOs should be held legally responsible when they breach these duties.

Making MCOs liable not only for their physicians' malpractice but also for other physician torts of the kinds mentioned would go far toward aligning the interests of physicians and financing entities and reducing plan-physician tensions that are at the heart of many of the problems facing managed care as we know it. Although such a legal regime would motivate risk-bearing entities to oversee physicians' work more carefully, making liability vicarious would preserve the integrity of physician-patient relationships. Thus, despite fears that professionalism is in jeopardy in the age of managed care, vicarious liability would strike an appropriate balance between professional duties and values on the one hand and the need for MCO accountability and better health care management on the other hand. Under vicarious liability, health plans and physicians would, for the first time, have a shared legal reason to look out for patients' welfare and the quality of care.⁵⁹ Such an alignment of plan and provider interests is essential to realizing the full promise of managed care.

VI. THE LAW TODAY

Under the law today, health plans and other MCOs are not liable for the torts of participating physicians unless the plaintiff can show certain special facts. The easiest case would be one in which an actual employment relationship exists, as in a staff-model health maintenance organization (HMO).⁶⁰ In other cases, liability may be determined by such factors as the degree of control actually exercised over the physician, the contractual relationship between the MCO and the provider, the

⁵⁹ A possible concern is that physicians participating in several MCOs (as many physicians currently do) would not be amenable to efforts by any one MCO to influence their practice style in the interest of improved quality. A related problem is that any individual MCO has a weak incentive to take aggressive quality-improving actions if its competitors will free-ride off of any success it achieves in modifying physician behavior. Physicians likely modify their practice style in treating *all* their patients, not only those of the MCO innovator. One possible solution to these problems might be collective action by MCOs to educate physicians and share quality-related information. See generally Robert A. Berenson et al., *Conceptual Issues in Collaboration*, in INSTITUTE OF MED., COLLABORATION AMONG COMPETING MANAGED CARE ORGANIZATIONS FOR QUALITY IMPROVEMENT 6, 6-32 (Molla S. Donaldson ed., 1999) (discussing what collective actions are possible within antitrust constraints). Another possibility is a tightening of physician networks, reversing the recent trend towards large unintegrated networks, and greater dependency by each physician on a small number of highly integrated MCOs. If vicarious liability adds significant new incentives for health plans and their subcontractors to organize physicians into efficient units dedicated to maximizing quality under cost constraints, it can be declared at least a qualified policy success.

⁶⁰ In *Sloan v. Metropolitan Health Council, Inc.*, 516 N.E.2d 1104, 1109 (Ind. App. 1987), the court held an HMO liable for an employee physician's negligence, despite the defense that "the professional must exercise a professional judgment that the principal [the HMO employer] may not properly control." The court observed that the HMO physicians were subject to some control by the plan's medical director.

individual plaintiff's reasonable beliefs concerning that relationship, the terms of the plan-subscriber contract and the objective tenor of any representations made by the plan. Vicarious liability for the acts of non-employee physicians is most likely when the plan has somehow held the physicians out as its agents.⁶¹ By the same token, a plan is probably off the hook if the operative contracts and descriptive literature conformed to conventional notions of the doctor-patient relationship and of the appropriate role of corporate entities in providing medical care.⁶²

It is common for courts to make actual control by a principal of the alleged agent a prerequisite for finding the former vicariously liable for the latter's torts.⁶³ As a matter of policy, however, it does not make sense to insulate health plans from liability simply because they primarily engage in paying for care and have no obvious ability, or inclination, to influence or control individual practitioners. A lack of organizational integration (and the consequential inability to control physician performance) should not be a basis for immunizing plans from liability for bad outcomes caused by independent contractor physicians. Instead, a health plan's hands-off policy in dealing with the physicians it selects (and compensates in ways possibly antithetical to the quality of care) could be seen as a strong reason to impose vicarious liability. Making liability presumptively vicarious under a default rule leaves plans free to shift liability downstream, thus overcoming the objection that plans themselves are often not equipped or in a good position to manage care.

A common law court might well sense some impropriety in allowing a health plan to profit as a middleman in health care transactions while denying responsibility for the quality of care. On this basis, it might decide to hold all such plans vicariously liable for physician negligence on the theory that the duty to provide non-negligent medical care was "non-delegable" to independent contractors. Although such a holding would find support in the law of agency,⁶⁴ it would be surprising in the instant context because health plans have never been legally recognized as having the initial responsibility for the quality of care. Certainly, a number of courts have held hospitals liable for the torts of nonemployee physicians working in a hospital emergency department.⁶⁵ Most, however, have found it difficult to call a function non-delegable by a corporate entity when public policy, as reflected in the rule that corporations may not "practice medicine," has traditionally viewed that function as an illegitimate one for a corporation, rather than a licensed individual, to perform. Unthinking adherence to this outdated paradigm of medical care explains why a legal

⁶¹ See, e.g., *Petrovich v. Share Health Plan, Inc.*, 719 N.E.2d 756, 763-68 (Ill. 1999); *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229, 1232 (Pa. Super. 1988).

⁶² See, e.g., *Petrovitch*, 719 N.E.2d at 765-68 (HMO denied summary judgment because physician's apparent agency was not dispelled by handbook or by membership certificate, which specified that physicians were independent contractors but was not shown to have been called to plaintiff's attention); see also *supra* note 23.

⁶³ See, e.g., *Petrovich*, 719 N.E.2d at 770-75 (summary judgment denied to HMO because its various ways of influencing physicians might be found to amount to sufficient control to justify finding implied agency, despite independent contractor relationship); *Chase v. Independent Practice Ass'n*, 583 N.E.2d 251, 253-54 (Mass. App. 1991) (attenuated relationship between plan, subcontractor and physician made control impossible, negating vicarious liability).

⁶⁴ See, e.g., RESTATEMENT (SECOND) OF AGENCY § 214 (1958) ("A . . . principal who is under a duty . . . to have care used to protect others . . . and who confides the performance of such duty to a servant or other person is subject to liability to such others for harm caused to them by the failure of such agent to perform the duty.").

⁶⁵ See CLARK C. HAVIGHURST ET AL., *HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS* 630-41 (1998) (collecting and discussing relevant legal materials).

system that allows MCOs to exercise control over the cost of health care remains fastidious about making them also responsible for its quality.

Despite the force of the paradigm that gave rise to the rule against corporate practice in the distant past, a court today might legitimately consider that public policy now contemplates, if not explicitly, at least in practice, that modern health plans will exercise a high degree of corporate influence over the nature and content of medical care. Health plans can restrict subscribers' freedom to select a provider, select subcontractors or individual physicians on the basis of the low prices they charge or the low costs they incur in treating patients, and reward subcontractors or individual physicians for economizing in patient care. Consequently, a court could reasonably hold that plans cannot avoid legal responsibility for the quality of care by delegating it to physician independent contractors, unless the court is bound by a contrary statutory mandate.⁶⁶ Courts are more likely, however, to apply principles of agency law in such a way as to make vicarious liability turn on the facts of each case, thus adding to the cost of litigating claims and creating incentives for MCOs to disclaim responsibility and to cease many of their efforts to control costs.⁶⁷ Finally, even if judge-made law could eventually solve the problem, it would take a long time for fifty state courts to get it right. Thus, if one accepts vicarious liability as a matter of policy, a strong case can be made for using a legislative route to update the law. Indeed, legislative reform of the kind proposed in this Article seems essential in order to get the law to reflect the market's clear acceptance of corporate medicine (even in imperfect form), to get the managed care industry to accept responsibility for the quality of care, and to set the stage for managed care to finally realize its immense promise.

VII. TORT LAW: PROBLEM OR SOLUTION?

Tort law has been widely castigated as a cause of serious problems in American health care for so long that it is rarely looked to anymore in designing solutions to those problems.⁶⁸ Thus, any suggestion, such as the one in this Article, that it can

⁶⁶ Another way to rationalize enterprise liability would be to draw from the law of products liability and recognize an "implied warranty" that the care provided will meet at least a minimum standard of quality. See generally William S. Brewbaker, III, *Medical Malpractice and Managed Care Organizations: The Implied Warranty of Quality*, LAW & CONTEMP. PROBS., Spring 1997, at 117, 133. As noted earlier, however, vicarious liability would preserve professional responsibility and might therefore pose a lesser threat to professionalism than this otherwise valid theory of enterprise liability. See *supra* note 53.

⁶⁷ See, e.g., *Petrovich*, 719 N.E.2d at 756. Many observers will be inclined to believe that common law courts, in holdings like *Petrovich* that make it relatively easy for a plaintiff to establish an HMO's vicarious liability, are making HMOs appropriately accountable and that legislation of the kind proposed here is not necessary. Yet the *Petrovich* holding clearly imposes vicarious liability only as a penalty for the HMO's interfering with medical decisions in the interest of cost containment and not as an inducement to encourage all plans to take a more active and constructive role in improving quality. *Id.* at 763-64, 770-76. Perversely, the signal to health plans is to take less, not more, responsibility for the quality of care.

⁶⁸ A recent Institute of Medicine conference examined "total quality management, marketplace competition, regulation, and payment incentives," as possible strategies for quality improvement "and found each strategy both promising and wanting." See Chassin, *supra* note 28, at 583. While legal liability was not regarded as a promising enough contributor to quality improvement to even be placed on the conference agenda, the paper on regulation addressed the topic in passing. See *id.* Cf. Brennan, *supra* note 51, at 720 ("Many do not consider tort law when addressing regulation of health care quality, despite the fact that this branch of law has as one of its major social goals . . . the deterrence of behavior that leads to medical injuries.").

and should be relied upon to send useful signals to health care providers is bound to encounter substantial skepticism. Nevertheless, because tort law and plaintiffs' lawyers are not going to go away, there is every reason to put them to their best possible uses.⁶⁹ If the tort system's benefits are to exceed its social costs to the greatest possible extent, the law's premises must be reexamined from time to time. This Article argues that adopting vicarious liability as a default rule could make medical malpractice law not only compatible with current marketplace realities but also a more clearly positive force for quality improvement.

Malpractice law does entail substantial transaction costs, mostly in the form of substantial payments to plaintiffs' and defense lawyers, expert witnesses and liability insurers. Indeed, the system is frequently criticized on the ground that less than half of the total premiums paid for liability insurance ever reach injured patients as compensation for their injuries.⁷⁰ If vicarious liability should increase the volume of malpractice claims, it might add to the transaction costs that society must bear. Significantly, however, vicarious liability, as proposed herein, would also *save* some transaction costs by eliminating defendants other than risk-bearing MCOs, thus reducing the cost and uncertainty of litigation and facilitating settlement negotiations.⁷¹

It is a serious mistake, however, to focus only on the malpractice system's costs and its obvious inefficiency as a compensation system and not to consider its other possible benefits. Most importantly, one should consider whether the malpractice system's deterrence signals contribute to efficiency in the system as a whole, thereby possibly justifying even heavy transaction costs.⁷² The main *raison d'être* of the tort system is, after all, to strengthen incentives for injury reduction that are frequently undersupplied in real-world markets. The medical malpractice system should therefore be viewed as especially pertinent today, when the overall quality of care and the efficacy of markets are being questioned and MCOs are being accused of undermining quality in their efforts to control costs. Under earlier, more generous payment systems, the risk that quality would be stinted was smaller than it is today, and the tort system therefore had a lesser role to play in quality assurance. Indeed, in the absence of cost constraints, it was alleged that the threat of malpractice liability exacerbated the system's inefficiency by inducing physicians to take too many precautions, practicing inefficient "defensive medicine." Today, however, the new economizing incentives reflected in the managed care movement have reduced concerns about defensive medicine, but they have also triggered legitimate concerns about over-economizing at the expense of quality. Precisely because the new health care system needs stronger incentives for quality enhancement, we should look to the tort system as an important source of consumer protection.

Vicarious liability, putting the legal onus for the quality of care initially on health plans that select and motivate providers, would be a good means of ensuring

⁶⁹ See Thomas B. Metzloff, *Understanding the Malpractice Wars*, 106 HARV. L. REV. 1169, 1169 (1993).

⁷⁰ See generally WEILER ET AL., *supra* note 27, at 77-109. In a public policy appraisal, only transaction costs, not total awards, should count against the system, because the amounts transferred to patients to compensate them for their injuries are not new social costs (although some observers would certainly object that shifting them would "increase the cost of health care"). See *id.* at 13-32.

⁷¹ But see Abraham & Weiler, *supra* note 38, at 406 (1994) (estimating that hospital-focused enterprise liability would save as much as 30% of litigation costs by eliminating multiple defendants).

⁷² See *supra* note 47.

that quality is not skimmed in the newly cost-conscious world of managed care. Unfortunately, however, there is no easy way to quantify the magnitude or the value to consumers of the quality improvements that vicarious liability might inspire or to compare those benefits with whatever increased transaction costs might be incurred. Nevertheless, judging from the recent Institute of Medicine Report and other critiques, improving management and implementing efficient practices in health care institutions and in clinical medicine could result in huge gains in patient welfare.⁷³ One reason why malpractice law has not served well in the past is that it thoroughly embraced the professional paradigm of medical care, focusing all responsibility and presumptive legal liability for patient injuries on the treating physician while ruling out any managerial role for corporate intermediaries. Today's circumstances suggest, however, that health care must be organized and managed, that it is already strongly influenced by financing intermediaries, and that few of those currently engaged in managing care are as concerned about its quality as they are about its cost. Efficiency requires that, at crucial points in the system, attention be paid to the ubiquitous trade-off between costs and quality and that choices be made between spending money on preventing iatrogenic injuries and tolerating some of them because prevention costs are too high. Vicarious liability would impose the relevant costs on the parties best able to evaluate and manage risks and would reflect *de jure* the shift of power and responsibility that has already occurred *de facto* in the health care marketplace. Moreover, it would do these things in conformity with time-tested principles of the common law of torts and agency as well as with the teachings of modern law and economics.⁷⁴

To argue that introducing vicarious liability would yield enough benefits to justify incurring some additional transaction costs is not to concede, however, that it *would* increase such costs significantly. Vicarious liability would potentially reduce per-case costs by streamlining litigation and facilitating settlements. Moreover, it is not certain that its adoption would increase either the frequency of claims or the size of judgments. Vicarious liability would increase the total number of malpractice claims only if it induced potential plaintiffs to bring more cases to the attention of lawyers, or if it altered lawyers' calculus in evaluating potential cases. It is true, as various studies have shown, that a huge reservoir of potential malpractice suits are never brought to the attention of liability insurers or the legal system.⁷⁵ If potential plaintiffs are reluctant to sue their personal physicians, then perhaps vicarious liability, together with the increased impersonality of managed care itself, would make victims of negligence more willing to consult a lawyer and to pursue claims. Yet vicarious liability would not diminish the need to demonstrate in court that the treating doctor was at fault, making it unclear how its adoption would change the propensity of potential plaintiffs to pursue their rights. In any event, even if injured patients were more inclined to sue, it might only mean that more negligence was

⁷³ See discussion *supra* note 25 and accompanying text.

⁷⁴ Patricia Danzon, a leading law-and-economics scholar, has questioned whether MCO liability would be desirable, given what she observes as the limited ability of health plans to control physician behavior. See Patricia Danzon, *Tort Liability: A Minefield for Managed Care*, 26 J. LEGAL STUD. 491, 502-16 (1997). Danzon did not consider, however, the possibility that vicarious liability might be made a limited default rule by statute, as proposed herein.

⁷⁵ See 1 HARVARD MED. PRACTICE STUDY, *supra* note 26, ch. 7; WEILER ET AL., *supra* note 27, at 61-64 (noting that in a New York study, "slightly more than 7 patients suffered a negligent adverse event for every patient who filed a tort claim"); see also Studdert et al., *supra* note 26, at 255 (reporting experience in Utah and Colorado).

effectively policed and that deterrence signals had been strengthened, yielding benefits in patient safety that more than compensate for any net increase in transaction costs. Critics of the tort system cannot easily argue both that it falls short in detecting actionable negligence and that vicarious liability should be resisted because it would increase the number and cost of claims.

It is not clear that vicarious liability would increase the willingness of plaintiffs' lawyers to pursue marginal malpractice cases in the expectation that the new allocation of responsibility would somehow make juries more likely to find liability or make generous damage awards. Although some mixed evidence suggests that corporate "deep pockets" face greater risks in the tort system than individual defendants,⁷⁶ this effect might be negligible in malpractice cases under vicarious liability. Because vicarious liability would be a default rule, the nominal defendant in many cases would be, not the health plan itself, but a subcontractor less likely to arouse any hostility jurors might feel against health plans. Moreover, vicarious liability should not shift juries' focus away from the issue of the individual physician's fault. Although plaintiffs' lawyers could try to implicate MCOs in physicians' malpractice, in many cases such a tactic would not be available or could be dangerous if it made the doctor seem any less culpable. Insofar as juries continued to perceive the issue as the culpability of individual doctors, malpractice cases might continue to feature a disproportionately high number of defense verdicts.⁷⁷ In any event, vicarious liability will not necessarily significantly increase the social costs incurred in operating the reparations system for medical accidents.

Whatever effect vicarious liability might ultimately have on the number and cost of malpractice claims, this Article argues that its adoption is supported by the simple need, in the new era of managed care, to put malpractice law back on the map as a main route to effective quality assurance. Even if the tort system's deterrence signals are relatively weak, they are more likely to induce quality improvements if they are directed at MCOs rather than individual doctors. Moreover, if putting the initial legal onus on health plans has any effect at all, it could only be to move the managed care revolution forward in a new, more desirable direction—toward overall efficiency, rather than merely intensified cost control. It would also legitimize greater corporate influence over clinical medicine by placing legal responsibility for quality squarely on corporate rather than exclusively on professional shoulders and by diminishing the force of physicians' argument that intermediaries care only about costs, not quality.

Finally, if the malpractice system is too costly to operate or sends signals that are either ill-conceived or too weak to inspire managerial reforms, the system should be improved, either through private contractual initiatives or through legislative action. Alternative, cost-effective methods of dispute resolution in malpractice cases

⁷⁶ See M. ROY SCHWARZ, *LIABILITY CRISIS: THE PHYSICIANS' VIEWPOINT*, MEDICAL MALPRACTICE—TORT REFORM 16, 24 (James E. Hamner & B.R. Jennings eds. 1987) (describing juries as "instinctively wish[ing] to help the plaintiffs as they would want others to help them if they were in a similar situation"). But see NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* 191-220 (1995) (citing but questioning, studies suggesting jury awards are more generous in malpractice cases than in other cases because "they perceive that the defendant cannot afford to pay more").

⁷⁷ See Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow*, LAW & CONTEMP. PROBS., Winter 1991, at 43, 64 n. 77, 115 (1991) (citing numerous studies that found relatively low plaintiff victory rates in medical malpractice cases and concluding that the empirical evidence tends to show a relatively low rate of plaintiff victories). The juries rendering such verdicts today are not likely to be under any illusion that physicians themselves, rather than their liability insurers, actually pay any judgments against them in malpractice cases.

could be introduced by contract or by legislation.⁷⁸ But substantive reforms may also be desirable. On the political front, "malpractice reform" is usually little more than a code word for legislative relief of physician-tortfeasors, not for strengthening the system as one of society's principal means of quality assurance. Nonetheless, shifting the liability burden to corporate actors through vicarious liability might change the political dynamics of malpractice reform in interesting ways. Thus, if physicians no longer felt that the system was principally designed to blame them individually for particular medical catastrophes and was instead being used to motivate major players to look out for patient welfare, physicians might come to support reforms aimed at improving patient care. Health plans themselves would lack the political clout and public sympathy they would need to resist system-strengthening reforms that lower the high litigation costs and other obstacles facing potential plaintiffs.

In summation, this Article's proposal to adopt vicarious liability as a universal default rule for medical malpractice is aimed at nothing less than permanently relocating responsibility for the quality of American health care. Its adoption could change fundamentally and desirably not only the focus and impact, but also the political environment, of legal efforts to compensate victims of medical malpractice and deter future injuries. It would also go far toward undermining some outdated paradigms that currently impede completion of the managed-care revolution. Although it is certainly true that "there is no 'magic bullet' that will solve th[e] problem [of improving patient safety],"⁷⁹ vicarious liability, addressing as it does both general concerns about the quality of U.S. health care and Americans' current dissatisfaction with managed care, deserves a front-and-center place in health policy debates as the Twenty-first Century begins.

⁷⁸ See HAVIGHURST, *supra* note 20, ch. 8 (suggesting that any one of the many malpractice reforms that have been considered for implementation through legislation should also be achievable by private contract).

⁷⁹ COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, *supra* note 25, at 3.

APPENDIX

PROPOSED STATUTORY LANGUAGE ESTABLISHING VICARIOUS LIABILITY

VICARIOUS LIABILITY OF HEALTH PLANS AND OTHER ENTITIES

(a) *In General.* Subject to the exceptions in subsection (b) but notwithstanding any other provision of law, a health plan shall bear vicariously the entire legal responsibility (as determined under state law), and shall alone be subject to suit, for personal injuries and other losses arising from care rendered by health care providers to enrollees under the contract between the health plan and the purchaser of coverage.

(b) *Contractual Exceptions.* A party other than a health plan may be subject to suit for personal injuries and other losses of the kind referred to in subsection (a) if the applicable contract between the health plan and its subscribers or enrollees (which contract shall be both binding on the enrollees of the health plan and enforceable by them against the health plan and health care providers with which the plan has arrangements to provide services) provides as follows—

- (1) in the case of inpatient or outpatient hospital care, that the hospital through or under the auspices of which the care is rendered shall bear the entire legal responsibility, and shall alone be subject to suit, for certain breaches of duty in connection therewith; or
- (2) in the case of care rendered through or under the auspices of an entity other than
 - (i) a hospital,
 - (ii) an entity that includes physicians practicing in several medical specialties but comprises fewer than fifty physicians, or
 - (iii) an entity that includes practitioners in only a single medical specialty or another licensed health profession but comprises fewer than five such practitioners,that such entity shall bear the entire legal responsibility, and shall alone be subject to suit, for any breach of duty in connection therewith; or
- (3) that an individual physician (or other professional practitioner or entity comprising professional practitioners) that is selected by the patient from a universe of options not significantly limited or preselected by the health plan shall bear the entire legal responsibility, and shall alone be subject to suit, for negligence or malpractice and for any other breach of duty in connection with care rendered to enrollees of the plan.

(c) *No Indemnification.* A health plan or other party that is subject to suit for personal injuries and other losses of the kind referred to in subsection (a) shall not seek indemnification for any resulting liability from any health care provider with which such health plan or other party had an arrangement to provide the service out of which such liability arose.